PROVIDER: Enter the be coded. For procedure Section I. Once approve SUPERVISOR: Review column marked "APPRO" recommendation and sig GENERAL: Critical casurgery. In addition, it rewith a variety of intensive specialty may include all inclusive nor exclusive.  NOTE: This document is  1 - Fully compercy - Modification 3 - Supervision 4 - Not requested 5 - Not requested.	appropriate provider code in the columns listed, line through and initial any crited, any revisions or corrections to this list veach category and/or individual privilegiveD". This serves as your recommendanture are required in Section II of this form medicine is a specialty that involves requires special expertise in the evaluation of ecare disorders to include medical, surgithose listed on DA Form 5440-3 or DA as to be used in conjunction with DA Form PROVIDER CODES tent to perform requested (Justification attached) requested and due to lack of expertise	marked "REQUES ria/applications the tof privileges will ge coded by the privileges will ge cod	STED". Each at do not app require you to rovider and er ander who is ageneral inter agnosis of an act. The diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis well as the first second control of the diagnosis of the diagnosis of the diagnosis well as the first second control of the diagnosis of	category and/or individual privilege listed must oly. Your signature is required at the end of to submit a new DA Form 5440.  Inter the appropriate approval code in the the approval authority. Your overall  Internal medicine and its subspecialties, or general and treatment of critically ill patients of all ages ostic and therapeutic modalities of this following procedures. This list is neither  al Privileges - Internal Medicine, or DA Form  APPROVAL CODES
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5 - Not requeste				ved, insufficient expertise
Requested Approved	ed due to lack of facility support			ved, insufficient facility support
Requested Approved	SECTION	- CLINICAL PRIV	LEGES	
todesores tribbiares		Requeste	d Approved	
	a. Pediatric intensive care disorders			q. Lumbar cerebrospinal fluid examination
	b. Treatment of respiratory failure			r. Percutaneous placement of peritoneal dialysis catheter
	c. Thoracentesis			s. Peritoneal lavage and dialysis
	d. Paracentesis			t. Continuous hemofiltration dialysis
	e. Pericardiocentesis			u. Cardioversion including defibrillation
	f. Arthrocentesis			v. Transvenous pacemaker insertion
	g. Tube thoracostomy			w. Balloon tamponade of bleeding esophagea
	h. Flexible tube broncoscopy			and gastric varices
	i. Transtracheal needle aspiration			x. Administration of conscious sedation
	j. Intubation - Oral and nasotracheal k. Percutaneous tracheostomy			y. Supervision and application of respiratory therapy; gas humidification; positive
	I. Ventilator management to include ra	oid		pressure ventilation; postural drainage and percussion
	frequency	ELECTIVE STATE		z. Other (Specify)
	m. Central monitoring line placement	NEW PROPERTY	THE REAL PROPERTY.	Z. Other jepteny
	n. Arterial line placement			
	o. Venous cutdown			
	p. Intracranial pressure monitoring			

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Approval as requested	Approval with Modificati	ions (Specify below)		Disapproval (Specify below)	
COMMENTS					
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DEPARTMENT/SERVICE CHIEF (Typed n	ame and title)	SIGNATURE			DATE (YYYYMMDD)
		30.17.18.0.000 y 0.000 0.000 0.000 0.000			A 2-100 of the 201 february 201 of the 2010 of the 201
	SECTION III - CREDENT	IALS COMMITTE	E RECOMME	NDATION	
Approval as requested	Approval with Modificati	ons (Specify below)		Disapproval (Specify below)	
COMMENTS					
	RSON (Name and rank)	SIGNATURE			DATE (YYYYMMDD)
CREDENTIALS COMMITTEE CHAIRPE	RSON (Name and rank)	SIGNATURE			DATE (YYYYMMDD)

EVALUATION OF CLINICAL PRIVILEGES - CRITICAL CARE MEDICINE (For use of this form, see AR 40-68; the proponent agency is OTSG.)				
1. NAME OF PROVIDER (Last, First, MI)	2. RANK/GRADE	3. PERIOD OF EVA	ALUATION (YYYYMMDD) TO	
4. DEPARTMENT/SERVICE	5. FACILITY (Name and Address: City/State/ZIP Code)			
INSTRUCTIONS: Evaluation of clinical privileges is based on the provider'	's demonstrated pati	ient management ab	ilities appropriate to this	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

CODE	PRIVILEGE CATEGORY	ACCEPTABLE	UN- ACCEPTABLE	NOT APPLICABLE
	a. Pediatric intensive care disorders	ACCEPTABLE	ACCEPTABLE	APPLICABLE
	b. Treatment of respiratory failure			
	c. Thoracentesis			
	d. Paracentesis			
	e. Pericardiocentesis			
	f. Arthrocentesis			
	g. Tube thoracostomy			
	h. Flexible tube broncoscopy			
	i. Transtracheal needle aspiration			
	j. Intubation - Oral and nasotracheal			
	k. Percutaneous tracheostomy			
	I. Ventilator management to include rapid frequency			
	m. Central monitoring line placement			
	n. Arterial line placement			
	o. Venous cutdown			
	p. Intracranial pressure monitoring			
	q. Lumbar cerebrospinal fluid examination			
	r. Percutaneous placement of peritoneal dialysis catheter			
	s. Peritoneal lavage and dialysis			
	t. Continuous hemofiltration dialysis			
	u. Cardioversion including defibrillation			
	v. Transvenous pacemaker insertion			
	w. Balloon tamponade of bleeding esophageal and gastric varices			
	x. Administration of conscious sedation			
	y. Supervision and application of respiratory therapy; gas humidification; positive pressure ventilation; postural drainage and percussion			
	z. Other (Specify)	\$6(21) 用 <b>9</b> (5)		

SECTION II - CON	MMENTS (Explain any rating that is "Unacceptable".)	
		1
NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE (YYYYMMDD)